URx Plan Exception Request
3404 Cooney Drive
Helena, MT 59602
Phone: 1-888-527-5879 for Questions
Fax: 1-406-513-1929

Plan Exception Request**

This form is to be completed by the prescribing provider and staff. Fax completed forms to 1-406-513-1929

Patient Information			
Patient's Name (Last, First, MI):		Policy Holder's Employer:	
Member ID:	Date of Birth:	Street Address:	
Member Phone Number:		City: State: Zip:	

Requesting Provider Information			
Requesting Physician/Provider's Name:			Specialty:
Street Address:	City:	State:	Zip:
Office Phone:	Office Fax:		
Office Contact Name:	Direct Line for Office Contact:		May we fax our response to your office? YES NO

Drug Information		
Requested Drug Name and Strength:	Quantity per month:	Diagnosis:
Directions:	Length of Therapy:	

List of previous drugs tried (if applicable to the request):

Drug Name and Strength:	Directions:	Duration /Dates Used:

Provide the **CLINICAL RATIONALE** for the requested drug tier OR quantity limit exception **(include chart notes and supporting labs as necessary):**

Requesting Provider's Signature: _____ Date: _____

Any additional information needed will be requested via telephone or fax.
Your office will be notified by fax of approval or disapproval; the patient will be notified in writing of approval or disapproval.

**** PLEASE NOTE: Copay Exceptions are not made for B or C tier medications**